



APPLICATION FOR ASSISTANCE

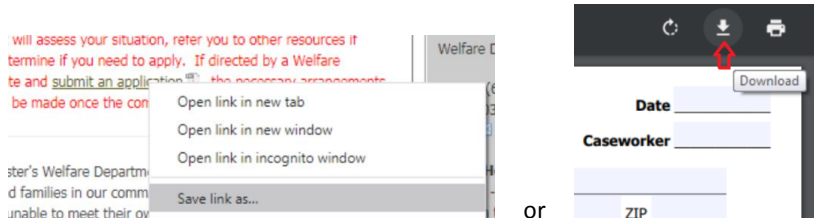
**CITY OF MANCHESTER
WELFARE DEPARTMENT • 1528 ELM STREET
PHONE : (603) 624-6484 • FAX: (603) 628-6179**

IMPORTANT!

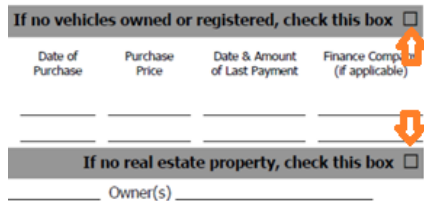
INSTRUCTIONS FOR FILLING OUT AND SUBMITTING YOUR APPLICATION

Please note that all instructions relate to using Windows 7/10 with Chrome browser. Completion of the application will also require a PDF Viewer, such as Adobe Reader.

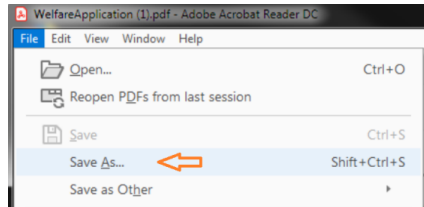
1. Download the application to your device PRIOR to filling out the application.



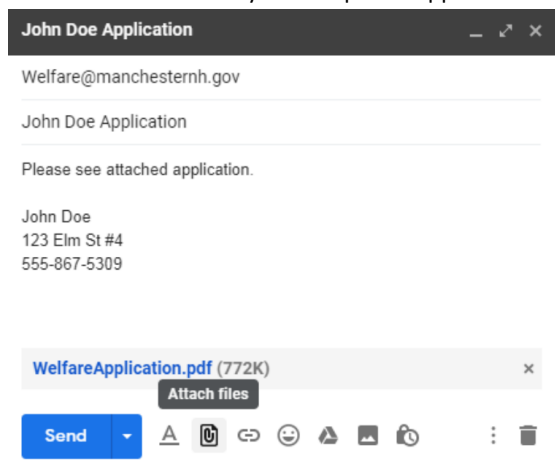
2. Open the application from the location to where it was saved. For example: My Documents, My Downloads, etc. Fully complete each section. If you have no information to put in a section, click the box in the top right.



3. Once finished, save your copy of the completed application.



4. If emailing, open your preferred email app (such as Gmail or Outlook). Compose a new email as pictured below. Make certain to attach your completed application and include your name, address, and best contact number.



5. If mailing your application, please mail to:
City of Manchester – Welfare Department
1528 Elm St
Manchester, NH 03101



City of Manchester, NH
Welfare Department
1528 Elm Street
Phone: (603) 624-6484
Fax: (603) 628-6179

APPLICATION FOR ASSISTANCE

Please complete each section

Date _____

Caseworker _____

Name _____

Phone # (_____) _____

Address _____

City _____ State _____ ZIP _____

Has anyone in the home applied here before? Yes ☐ No ☐

If yes, when: _____ What name: _____

HOUSEHOLD INFORMATION:

List all current household members, including temporary or part-time guests:

| | Full Legal Name | Relationship | Marital Status | Birthdate | Age | Social Security Number | Most Recent School Attended |
|----|-----------------|--------------|----------------|-----------|-----|------------------------|-----------------------------|
| 1. | | SELF | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |
| 6. | | | | | | | |

Has anyone left the home in the last 30 days? Yes ☐ No ☐ If yes, name: _____ When: _____

CHILDREN (OVER & UNDER 18) LIVING ELSEWHERE:

If none, check this box ☐

| | Full Legal Name | Age | Address | Employer (if working) | Custodial Guardian (if under 18) |
|----|-----------------|-----|---------|-----------------------|----------------------------------|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |

MARRIAGE HISTORY:

If no current/prior marriages, check this box ☐

| | Name | Spouse | Date of Marriage | State Married In | Legal Status (divorced / separated / widowed) | Date Divorced / Separated / Widowed |
|----|------|--------|------------------|------------------|---|-------------------------------------|
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |

ADDRESS HISTORY:

Starting with the most recent, list your current and prior two addresses:

| | Street Address & Unit # | City / Town | State | From (month/day/year) | To (month/day/year) |
|----|-------------------------|-------------|-------|-----------------------|---------------------|
| 1. | CURRENT ADDRESS | | | | TODAY |
| 2. | | | | | |
| 3. | | | | | |

BIRTHPLACE AND PARENTAL INFORMATION:

List each adult's place of birth and information for both of their parents:

Your Name _____

Your Name _____

Birthplace _____

Birthplace _____

Father _____ Tel # (_____) _____

Father _____ Tel # (_____) _____

Address _____ Deceased? ☐

Address _____ Deceased? ☐

Mother _____ Tel # (_____) _____

Mother _____ Tel # (_____) _____

Address _____ Deceased? ☐

Address _____ Deceased? ☐

| | Name | Branch | Dates of Service | Type of Discharge | Benefits, if Any |
|----|------|--------|------------------|-------------------|------------------|
| 1. | | | | | |
| 2. | | | | | |

| Name | Employer | Date and Amount of Last Pay | Paper Check | Direct Deposit | Dates of Employment | Reason for Leaving |
|------|----------|-----------------------------|--------------------------|--------------------------|---------------------|--------------------|
| | 1. _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| | 2. _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| | 3. _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| | 1. _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| | 2. _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| | 3. _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |

Where _____

| | | |
|---------------------|------------------------|---|
| Name _____ | Medical Issue(s) _____ | On Medication? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Doctor's Name _____ | Address/Location _____ | Tel # (_____) _____ |
| Name _____ | Medical Issue(s) _____ | On Medication? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Doctor's Name _____ | Address/Location _____ | Tel # (_____) _____ |
| Name _____ | Medical Issue(s) _____ | On Medication? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Doctor's Name _____ | Address/Location _____ | Tel # (_____) _____ |

| | | |
|---|---------------------------------------|--|
| Name _____ | Date of Illness/Accident/Injury _____ | Work-related? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If work-related: Employer _____ | Address _____ | Tel # (_____) _____ |
| Work limitations? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, details: _____ | Return to work date _____ | |

| | | |
|---|---------------------------------------|--|
| Name _____ | Date of Illness/Accident/Injury _____ | Work-related? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If work-related: Employer _____ | Address _____ | Tel # (_____) _____ |
| Work limitations? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, details: _____ | Return to work date _____ | |

| | Name | Insurance Company | Policy Type (auto, renters, etc.) | Monthly Cost | Date of Last Payment | Cash Value (if applicable) |
|----|------|-------------------|-----------------------------------|--------------|----------------------|----------------------------|
| 1. | | | | | | |
| 2. | | | | | | |

CAR / VEHICLE INFORMATION:**If no vehicles owned or registered, check this box** ☐

| Year | Make & Model | Registered To | Ownership Status (own, loan, lease, borrow, etc.) | Date of Purchase | Purchase Price | Date & Amount of Last Payment | Finance Company (if applicable) |
|----------|--------------|---------------|---|---------------------|-------------------|----------------------------------|------------------------------------|
| 1. _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |

HOME OWNERSHIP / PROPERTY INFORMATION:**If no real estate property, check this box** ☐

Property Address(es) _____ Owner(s) _____

Purchase Date _____ Price _____ Mortgage Company _____

Monthly Mortgage Payment _____ Are Taxes Escrowed? Yes ☐ No ☐ Amount of Property Tax Bill _____

RENTAL INFORMATION:**If not renting, check this box** ☐

Landlord _____ Tel # (_____) _____ Address _____

Rental Amount _____ Weekly ☐ / Monthly ☐ / Other ☐ Date Last Paid _____ Amount Paid _____

Current Balance Owed _____ Included Utilities: Heat ☐ Hot Water ☐ Electric ☐ # of Bedrooms _____

Lease? Yes ☐ No ☐ If yes, list all names on lease: _____ Cosigner? Yes ☐ No ☐

Rental Subsidy? Yes ☐ No ☐ If yes, which agency: _____ Utility Allowance? Yes ☐ No ☐

Eviction? Yes ☐ No ☐ If yes, expiration/quit date: _____ Prior Evictions? Yes ☐ No ☐

TAX INFORMATION:**If no taxes filed in the past year & no one claimed, check this box** ☐

Provide information for all tax returns filed within the past year:

| Name | Date Last Filed | Tax Preparer | Refund? | Owe? | Refund / Payment Amount | Date Received/ Expected | Paper Check | Direct Deposit |
|----------|-----------------|--------------|--------------------------|--------------------------|----------------------------|----------------------------|--------------------------|--------------------------|
| 1. _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Did anyone NOT in the home claim any of your children on their taxes? Yes ☐ No ☐ If yes, Name: _____**FINANCIAL INFORMATION:****If no accounts & none closed in last 6 months, check this box** ☐

Provide balances of all financial accounts, including on-line, pre-paid or any other type of accounts:

| Your Name | Name of Bank or Company | Savings Account | Savings Balance | Checking Account | Checking Balance | Other Account (internet, pre- paid, etc.) | Other Balance |
|-----------|-------------------------|--------------------------|-----------------|--------------------------|------------------|---|---------------|
| 1. _____ | _____ | <input type="checkbox"/> | _____ | <input type="checkbox"/> | _____ | <input type="checkbox"/> | _____ |
| 2. _____ | _____ | <input type="checkbox"/> | _____ | <input type="checkbox"/> | _____ | <input type="checkbox"/> | _____ |
| 3. _____ | _____ | <input type="checkbox"/> | _____ | <input type="checkbox"/> | _____ | <input type="checkbox"/> | _____ |

Has any household member closed any financial accounts in the past 6 months? Yes ☐ No ☐ If yes, when: _____

Name _____ Name & Location of Financial Account _____ Type of Account _____

Does any household member have any of the following types of accounts? 401K ☐ 403b ☐ Trusts ☐

Certificates of Deposit (CDs) ☐ Retirement Accounts ☐ Stocks/Bonds ☐ Annuity ☐ Other ☐

In the past 6 months has anyone borrowed from, cashed in, or received money from any of the above accounts? Yes ☐ No ☐

If yes, name: _____ Type of Account _____ Date & Amount Last Received _____

In the past 6 months have any household members participated in any donation or charitable fundraising? Yes ☐ No ☐

If yes, provide details: _____

BENEFIT & RESOURCE INFORMATION:

Provide information for all benefits & resources. Check the box in the 2nd column if you do not have the listed benefit/resource:

| | Check if None | Name of Person Receiving | Date Applied | Date Last Received | Amount Last Received | Cash or Paper Check | Direct Deposit |
|---|--------------------------|-----------------------------|-----------------|-----------------------|-------------------------|---------------------------|--------------------------|
| ANB (Aid to the Needy Blind) | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| APTD (Aid to Permanently & Totally Disabled) | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Child Support | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Employer-Related Short / Long Term Disability | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Employment/Work Income | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Food Stamps | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Fuel/Electrical Assistance | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Gifts / Loans (from friends, relatives, etc.) | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Housing Utility Allowance | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Medicaid / Medicare | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| OAA (Old Age Assistance) | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Retirement / Pension | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Severance Pay | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| SSDI (Social Security Disability) | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| SSI (Supplemental Security Income) | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Social Security (Other) | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| TANF (Temp. Assistance for Needy Families) | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Unemployment Benefits | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Veteran's Disability / Pension | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| WIC / Commodity Foods | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Workers' Compensation | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: _____ | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: _____ | <input type="checkbox"/> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |

How much total cash is currently available: _____

PAST / FUTURE RESOURCES:

Is any household member expecting to receive, or has received in the past year, any of the following: Yes ☐ No ☐

Retroactive Disability (SSDI/SSI/APTD) ☐ Inheritance ☐ Insurance Claim ☐ Workers' Comp. Settlement ☐

Any Other Type of Claim/Settlement/Payment ☐ If yes to any, provide details: _____

Is any household member consulting with an attorney for any reason? Yes ☐ No ☐

If yes, provide details: _____

Is any household member working with another agency, or enrolled in post-high school classes? Yes ☐ No ☐

If yes, provide details: _____

GUARDIANSHIP / REPRESENTATIVE PAYEE

If no guardians/rep payees, check this box ☐

Does any household member have a guardian or rep payee, or is any household member one for someone else? Yes ☐ No ☐

If yes, provide details: _____

BILLS & EXPENSE INFORMATION:

Provide information on all household bills & expenses. Check the box in the 2nd column if you do not have the listed expense:

| BASIC EXPENSES | Check if None | Amount | Frequency (weekly / monthly) | Date Last Paid | Name Listed on Bill | Balance Due | Automatic Withdrawal? |
|-------------------------|--------------------------|--------|---|----------------|---------------------|-------------|--------------------------|
| Rent / Mortgage | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| Food | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| Car Gas | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| Diapers | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| Household Supplies | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| Laundry | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| Electric | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| Gas Utility | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| Oil | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| Prescriptions | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| OTHER EXPENSES | | | | | | | |
| Cable/Satellite | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| Car Payments | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| Child Care | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| Court Fees, Fines, etc. | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| Credit Cards | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| Internet | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| Personal Loans | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| Pet Expenses | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| Phone | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| Rent-to-Own Items | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| Smoke / Vape Products | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| Storage Units | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| Streaming (Hulu, etc.) | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |
| Other _____ | <input type="checkbox"/> | | Wk <input type="checkbox"/> Mo <input type="checkbox"/> | | | | <input type="checkbox"/> |

CHILD SUPPORT PAID OUT:

If no minor children, check this box ☐

Is any household member required to pay child support for a child living with someone else? Yes ☐ No ☐

For what child _____ Paid to: Name _____ Address _____

Their relation to child _____ Date & amount last paid _____ Next due _____ Court ordered? Yes ☐ No ☐

For what child _____ Paid to: Name _____ Address _____

Their relation to child _____ Date & amount last paid _____ Next due _____ Court ordered? Yes ☐ No ☐

CHILD SUPPORT RECEIVED:

If no minor children, check this box ☐

Is any household member supposed to receive child support from someone not living in the home? Yes ☐ No ☐

For what child _____ Received from: Name _____ Address _____

Their relation to child _____ Date & amount last received _____ Next due _____ Court ordered? Yes ☐ No ☐

For what child _____ Received from: Name _____ Address _____

Their relation to child _____ Date & amount last received _____ Next due _____ Court ordered? Yes ☐ No ☐

CRIMINAL HISTORY:**If no felony record, probation, or parole, check this box** ☐

Provide information on all felony convictions for all household members:

Name _____ Felony Conviction(s) _____

Probation/Parole? Yes ☐ No ☐ State _____ Probation/Parole Officer _____ Tel # (____) _____

Name _____ Felony Conviction(s) _____

Probation/Parole? Yes ☐ No ☐ State _____ Probation/Parole Officer _____ Tel # (____) _____Has anyone in the household been convicted of arson or of any other offense requiring ongoing registration? Yes ☐ No ☐**ASSISTANCE REQUESTED:**

What assistance are you requesting?

What is the reason for your request?

CONTINUE TO PAGE 7, REVIEW AND SIGN BOTH PAGES 7 AND 8**SPACE BELOW FOR OFFICIAL USE ONLY**Applicant/Client Responsibilities reviewed & copy provided ☐**DO NOT SIGN BELOW UNTIL AFTER THE INTAKE INTERVIEW**

I hereby certify that all of the information I have provided both in writing and verbally to Manchester City Welfare is complete and true. I hereby certify that all notes and/or alterations written on my application by the Welfare Official(s) during the intake process accurately reflect my responses to questions and any additional information that I provided. I understand that if I knowingly give false or misleading information or withhold or omit information related to my receipt of assistance, now or in the future, I may be determined ineligible for assistance and I may be prosecuted for a crime (i.e. RSA 641:3 – Unsworn Falsification and/or RSA 637:4 – Theft by Deception).

Applicant Signature: _____ **Date:** _____**Applicant Signature:** _____ **Date:** _____**Applicant Signature:** _____ **Date:** _____**Applicant Signature:** _____ **Date:** _____

Applicant Name (PRINT)

Applicant Name (PRINT)

Applicant Name (PRINT)

Applicant Name (PRINT)

READ BEFORE SIGNING

My signature below constitutes the granting of my authority for the City of Manchester, NH Welfare Department to obtain verification and/or proof from all sources concerning my household's circumstances. All information supplied by me is subject to investigation and verification.

I have the right to request a fair hearing based on the receipt of an adverse action issued by a Welfare Official.

I, the undersigned, agree to repay the City of Manchester, NH Welfare Department for any assistance granted pursuant to RSA 165.

Applicant Signature

Date

Applicant Signature

Date

Applicant Signature

Date

Applicant Signature

Date

APPLICANT'S AUTHORIZATION TO FURNISH INFORMATION

I authorize any relative, landlord/rental/leasing agent, utility provider, employer, banking/financial institution, school department, insurance company, day care provider, health care provider, mental health professional, pharmacy, hospital, funeral home, law enforcement agency, fire department, food pantry, shelter, domestic violence or crisis organization, faith-based organization, municipal welfare official, lawyer, or any other person, company, organization or agency, having information concerning my circumstances to furnish such information to the City of Manchester, NH Welfare Department. I also authorize the Department of Health and Human Services, Social Security Administration, Department of Homeland Security, Department of Employment Security, NH Legal Assistance, Internal Revenue Service, Veteran's Administration, Southern New Hampshire Services, or any other government or social service organization to furnish all information concerning my circumstances to the City of Manchester, NH Welfare Department.

Applicant Signature

Date

Applicant Signature

Date

Applicant Signature

Date

Applicant Signature

Date

APPLICANT'S AUTHORIZATION TO RELEASE INFORMATION

I authorize the City of Manchester, NH Welfare Department to release information concerning my circumstances to any person, company, organization or agency including but not limited to those cited above when doing so is deemed necessary by the City of Manchester, NH Welfare Department for the determination of my eligibility and/or the administration of welfare.

Applicant Signature

Date

Applicant Signature

Date

Applicant Signature

Date

Applicant Signature

Date

**If you need a disability-related accommodation, notify front desk.
 TTY access through Relay NH at 711**

APPLICANT/CLIENT RESPONSIBILITIES

From the time of the initial application, and as long as a client is receiving assistance or their case is open, the client shall comply with each of the following responsibilities:

- to submit a completed, signed Application for Assistance, including any supporting documentation; all information provided (verbal and written) must be accurate and truthful in all respects and without misrepresentation and/or omission;
- to cooperate fully in answering all material questions asked by the Welfare Official, including providing information regarding all legally liable relatives. (RSA 165:19) Refusing to answer all material questions asked by the Welfare Official shall be considered withdrawal of application for assistance;
- to comply with all requirements set forth in each Notice of Decision;
- to report to the Welfare Official, at each appointment, any and all changes in circumstances, particularly having received and/or benefited from, directly or indirectly, any financial resources from any source;
- to apply for and accept any benefit or resource (public or private) within seven (7) days of being directed to do so by a Welfare Official and to fulfill all ongoing requirements of such programs;
- to cooperate fully with the Welfare Official in verifying all information that has been provided and is necessary to determine eligibility;
- to keep all appointments as scheduled unless an emergency prevents keeping the scheduled appointment. In such an event, providing documentation of the emergency may be required;
- to provide records and other required information, as well as to provide access to such records and information, when required;
- to provide a Request for Medical Information Form completed by a licensed medical provider as to the level of work that can be performed by a client, if they are claiming their ability to work is restricted or prohibited;
- to immediately report any claim of theft or loss of money, voucher or other valuable property to the appropriate entity and law enforcement, and to provide the Welfare Official with proof of the report to law enforcement;
- to search diligently for any employment, as directed by the Welfare Official;
- to provide verifiable documentation of work search, with the number of work search contacts being determined by the Welfare Official;
- to accept any employment when offered, except for documented reasons of good cause and to maintain such employment once assistance has been granted. (RSA 165:1-d);
- to participate fully in the Welfare Department Work Program, if physically and mentally able. (RSA 165:31);
- to cooperate fully with the Welfare Official in obtaining reimbursement to the Welfare Department for assistance provided and to notify the Welfare Official of any pending civil judgments, lawsuits, inheritances, financial settlements, insurance claims or any other financial awards;
- to reimburse the Welfare Department for any assistance granted, when and if returned to an income status that would allow for such reimbursement to be made without financial hardship. (RSA 165:20-b); and
- to read and sign the Applicant/Client Responsibilities Form which has been provided.

A client may be suspended or determined ineligible for assistance for failure to fulfill any of the above responsibilities without verifiable good cause.

Applicant Signature

Date

Applicant Signature

Date

Applicant Signature

Date

Applicant Signature

Date